New Hampshire Insurance Department

MANAGED CARE CONSUMER GUIDE TO EXTERNAL APPEAL

New Hampshire law gives you the right to an external appeal when health care services are denied by your managed care insurer on the basis that the services are not medically necessary or that the services are experimental or investigational.

WHAT IS AN EXTERNAL APPEAL?

- An external appeal is a request that you make to the state for an independent review of a denial of services by your managed care insurer.

- Reviews are conducted by Independent Review Organizations (IROs) that are certified by the state and have a network of medical experts to review your health insurer's denial of services.

- You must complete the attached application and submit the application and all supporting documentation to the New Hampshire Insurance Department to request an external appeal.

WHEN IS MY APPEAL ELIGIBILE FOR INDEPENDENT EXTERNAL REVIEW?

To be eligible for independent external review, the following conditions must be met:

- The service that is the subject of the appeal request must be a covered benefit under the terms of your health insurance policy or at least something that could be a covered benefit in some circumstances.

- You must have completed the internal appeal process provided by your insurer and received a final decision from your insurer. However, this requirement need not be met if your insurer agrees in writing to submit its decision to independent external review prior to completion of internal review. In addition, if you have requested first or second level internal review and have not received a decision from your insurer within the required time frames, you may proceed to external review without having received a decision from your insurer on internal review.

- You must submit your request for independent external review to the New Hampshire Insurance Department within 180 days of the date that you were first eligible to file for review. Normally, this will be the date of the health insurer's written, second-level denial decision on internal review.

- The cost to you for the service that the health insurer has denied must amount to at least $400 in a 12-month period.

- Your request for an independent external review must not be for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence, or other professional fault.

TYPES OF HEALTH INSURANCE FOR WHICH EXTERNAL REVIEW IS NOT AVAILABLE

In general, independent external review is available only for private, managed care health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's external review law:

- Medicaid, the State Children's Health Insurance Program, Medicare, or services provided under these programs but through a contracted health insurer.

- All other government-sponsored health insurance or health services programs.

- Health benefit plans that are self-funded by employers.

CAN SOMEONE ELSE REPRESENT ME IN MY EXTERNAL APPEAL?

Yes, you may designate anyone you would like, including your treating health care provider, to represent you. To do so, you must fill out the section of the external appeal request form entitled, "Appointment of Authorized Representative." You may also revoke this authorization at any time.

FILING THE EXTERNAL APPEAL

You, or someone acting on your behalf with your written consent, may request an independent external review by filling out the attached external appeal request form and submitting it to the New Hampshire Insurance Department together with the required supporting documentation. There is no cost to you for an external review. Please be sure to include all of following with your appeal:

- A completed external appeal request form.

- A copy (if you received one) of the letter from your health insurer denying your request at the second and final level of their internal appeal process.

- A photocopy of your insurance card or other evidence that you are insured by the health insurance company named in your external appeal request form.

- A copy of your certificate of coverage or your insurance policy benefit booklet, which lists your benefits.

- Any medical records, statements from your treating health care providers, or other information that you would like the independent review organization to consider in reviewing your case.

You may call the Insurance Department at 800-852-3416 or 271-2261 if you need help with the application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for independent external review.

If you are requesting a standard appeal, send all paperwork to:

Independent External Review
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

If you are requesting an expedited appeal, call the Insurance Department before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

WHAT IS THE STANDARD APPEAL PROCESS AND TIME FRAME?

- Within 7 business days after receiving your request for an independent external review, the Insurance Department will complete a preliminary review to determine whether your request is complete and whether your case is eligible for external review. If the request is not complete, the insurance department will inform you or your representative what information or documents are needed to make the request complete and to process the request. You will have 10 days to supply the needed information or documents.

- If the request for external review is accepted, the insurance department will select and retain an independent review organization to conduct the review and notify you and the insurer.

- Within 10 days after receiving notice of the acceptance of the appeal, the insurer must provide the selected independent review organization and you all information in its possession that is relevant to the appeal. You, or your representative, will then have another 10 days to submit new or additional information to the independent review organization and the insurer if you would like. During this 10 day period, you or your representative may also present oral testimony via teleconference to the independent review organization and the insurer. However, oral testimony will be permitted only in cases when the commissioner determines that it would not be feasible or appropriate to present only written information. If you or your representative would like to discuss your case with the independent review organization and your insurer in a telephone conference, you can request this by checking the

appropriate box in the external appeal request form or by contacting the Insurance Department no later than 10 days after receiving notice of the acceptance of the appeal.

- At the end of this second 10 day period, the record of the case will be closed and no new information may be provided. The independent review organization will then have 20 days to review all of the information and documents received and render a decision upholding or reversing the determination of the insurer.

EXPEDITED EXTERNAL REVIEW

Because the standard process for handling external review can take over 47 days, expedited (fast-tracked) external review is available for those persons who would be significantly harmed by having to wait. You may request expedited review by checking the appropriate box on the appeal request form and by having your treating health care provider fill out a certification form, which is attached to the appeal request form, verifying that adherence to the time frame for standard review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. Expedited review must be completed in at most 72 hours.

If you are pursuing an internal appeal with your insurer and anticipate that you may be requesting external review on an expedited basis, please call the Insurance Department at 800-852-3416 or 271-2261 in advance, so that accommodations can be made to receive and process your request as quickly as possible.

WHAT HAPPENS WHEN AN INDEPENDENT REVIEW ORGANIZATION MAKES ITS DECISION?

- If your appeal was expedited, in most cases you and your health insurer will be notified of the independent review organization's decision immediately by telephone or fax. Written notification will follow.

- If your appeal was not expedited, you and your health insurer will be notified in writing.

- The decision of the independent review organization is binding on the health insurer and is enforceable by the Insurance Department. The decision is binding on you as well, except that it does not prevent you from pursuing any other claim or remedy you may have under federal or state law.

If you have any questions, please contact the New Hampshire Insurance Department at 800-852-3416 or 271-2261 and ask to speak to a consumer assistant.